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	17E473	A. BUILDING _____ B. WING _____	07/27/2011

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COFFEY COUNTY HOSPITAL LTCU	128 S PEARSON AVE WAVERLY, KS 66871

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F 000	INITIAL COMMENTS The following citations represent the findings of a health re-survey and complaint investigation # 48168.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		7/28/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/05/2011

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including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and

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provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents with 11 selected for sample review. Based on observation, record review, and interview, the facility failed to provide information to the residents, on an on-going basis, regarding the rights of the resident's of the facility.

Findings included:

- Observation on entry, initial tour and the subsequent environmental tour, on 7/21/11 at approximately 3:00 p.m., failed to identify the facility posted the required information for contacting the state ombudsman.

The monthly resident council minutes, for the

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F 156	Continued From page 3 2011 year, failed to identify the facility reviewed the resident rights with the resident council group, for the 2011 year, a period of 7 months. Interview on 7/25/11 at approximately 3:00 p.m., with one interviewable, anonymous resident, identified the staff fail to provide information to the residents attending resident council meetings with any review of the resident rights, unless someone would specifically question that particular right. The resident further indicated the residents lacked access to the ombudsman phone number. Interview, on 7/25/11 at 5:15 p.m. with administrative staff L, reported not aware of any review of the resident rights during resident council meeting and the staff would address the issue. Additionally, staff indicated the facility posted the information for contacting the ombudsman, in the staff lounge. The facility failed to provide the residents of the facility, with an on-going method of reviewing their resdient rights and access to the ombudsman phone number.	F 156		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents. The 11 residents selected for review, included 3	F 221		8/9/11

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with physical restraints. Based on observation, interview,and record review the facility failed to ensure freedom from physical restraints for 1 (#17) of the 3 residents sampled with physical restraints..

Findings included:

- The 5/3/2011 MDS (Minimum Data Set) identified resident #17 with diagnoses which included anemia, atrial fibrillation, hypertension, arthritis, anxiety disorder , Alzheimer's disease, and severely impaired cognitive skills. The assessment also documented the resident used a restraint used daily, identified as a chair which prevents rising.

The current undated care plan, documented use of the Merry Walker from 10/1/2009 to present, to promote independence. The care plan instructed staff to check with the resident often to ascertain his/her needs, and to reposition between walker and recliner every 2 hours.

The 6/14/11, Pre-restraining assessment documented the resident as alert,disoriented, unsteady on their feet, loses balance, a history of falls, leans backward/forward, does not understand what is being said, cannot comprehend surroundings, affected by environmental noise level, and misinterprets words/sounds. Recommendations documented to continue plan of care with no Plan of Care updates, and the next evaluation 9/11.

Observation on 7/20/11 at 1:35 PM , revealed the resident in the Merry Walker in the hallway, eyes closed, body slumped down in the seat and with head down.

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At 1:50 PM, the resident moved the Merry Walker down the East hallway. The resident remained seated, and moved the walker with their feet, and scooted forward on the seat, almost sitting on the strap. Certified nursing staff DJ, repositioned the resident at 2:10 PM, and pushed the Merry Walker to the dining room for cake and ice cream.

On 7/21/11 at 9:25 AM, certified nursing staff D and A, assisted the resident to transfer from the Merry Walker to the toilet. Staff A stated, "The resident no longer stands and walks with the Merry Walker alone, usually only when staff walks beside the resident.

On 7/21/11 at 2:50 PM, certified nursing staff Z, stated they worked at the facility for over 2 years. Staff Z, reported they had not witnessed the resident walking in the merry walker alone as they used to do, and explained the resident now just pushed their feet to move the Merry Walker.

On 7/25/11 at 10:30 AM, certified nursing staff T, reported the resident no longer stood and walked with the Merry Walker, just moved their feet over the floor to scoot it, and stated the resident had not stood up and walked with it for several months.

On 7/25/11 at 12:30 PM, licensed staff K, stated the resident no longer stood to walk with the Merry Walker, just used their feet to move it, and added they did not remember when the resident stopped standing to walk with it.

On 7/25/11 at 1:19 PM, licensed nursing staff M, reported they complete the pre-restraining assessment quarterly. " The Merry Walker is the

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F 221	Continued From page 6 least restrictive device for the resident, and does not need a therapist evaluation to tell them that. A therapist does come in once a week to the facility, but no therapy screens for him/her, to say the Merry Walker is the least restrictive device. The resident no longer stood up and walked in the merry walker, that he/she did walk with staff walking beside the walker, and felt the walker was the best assistive device for the resident. The resident would just have increased falls if placed in a wheelchair. The facility had not tried the resident in a wheelchair since going to the merry walker or since the resident had stopped standing and walking in the Merry Walker." The facility May 2011, Physical Restraint Policy stated: "To continually reassess the resident's functional status to determine that the medical condition requiring restraint continues, that any decline in functional status is related to medical condition, not restraint use, and that negative effects are monitored; no unanticipated negative effects are occurring and benefits continue to outweigh risks." The facility failed to assure this resident remained free from a physical restraint, imposed for the purpose of convenience, and not and not required to treat the resident's medical symptoms.	F 221		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		7/28/11

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F 226	Continued From page 7 This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents. Based on observation, interview and record review, the facility failed to complete verification of certification for one of 5 staff members reviewed, prior to employment of the certified staff. Findings included: - Review of employment records, on 7/19/11 with administrative staff L, identified a lack of nurse aide registry verification for one CNA (certified nurse aide)employee, with a hire date of 3/8/11. Interview on 7/21/11 at 9:30 a.m., with administrative staff L, reported, "I usually contact the registry before employment." The undated, facility policy for Resident Abuse/Reporting/Investigation/Action, identified, "...The Director of Long Term Care and the Human Resources Director of [the facility] will ensure all potential employees are screened for history of abuse and/or criminal record:...Certification of CNA's (certified nurse aides) will be verified prior to employment..." The facility failed to ensure the residents of the facility remained free from abuse of neglect, when staff failed to verification employment eligibility for one certified staff member from 3/8/11 to 7/20/11, a period of 4 months and 12 days.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		8/9/11

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The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 34 residents with 11 residents sampled. Based on observation, interview and record review, the facility failed to speak in a respectful manner that enhanced dignity for one sampled resident (#12).

Finding included;

- According to the clinical record, the facility admitted resident #12 on 9/17/10. Review of the Physician's Order Sheet, dated 6/1/11, recorded diagnoses that included anemia, constipation, anxiety, hypothyroidism, depression, hypertension, hypercholesterolemia, gastroesophageal reflux, and dementia.

Review of the most recent Resident Assessment Protocol summary, dated 9/30/10, recorded the resident required minimal to moderate assistance of one staff member for all activities of daily living due to cognitive deficits.

Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 6/14/11, recorded the resident with a Brief Interview for Mental Status (BIMS) score of (1) that indicated severely impaired cognition, and documented the resident with short and long-term memory impairment, moderately impaired decision-making and staff assistance with activities of daily living.

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Review of the resident's plan of care, dated 6/21/11, lacked evidence the resident preferred a "nickname" or name other than his/her own.

Observation during personal cares on 7/21/11 from 3:15 P.M. to 3:30 P.M., revealed direct care staff B and J responded to the resident using "Babe" or "Honey" a minimum of 10 times and failed to call the resident by his/her given name. The resident stated "don't put me in this water", direct care staff J responded and said, "Oh, I know Honey."
In response to the resident stating, "I'm freezin", direct care staff B consoled the resident and said, "I know, Babe. I know you're cold."

On 7/25/11 at 8:50 A.M., direct care staff F assisted the resident up from the dining table and called the resident "Honey".

On 7/25/11 at 10:40 A.M., licensed nursing staff I, reported that staff address residents by their name of choice.

On 7/25/11 at 1:30 P.M., direct care staff D reported the resident preferred to be addressed by his/her first name.

On 7/25/11 at 1:30 P.M., direct care staff F, reported the resident preferred to be called by his/her first name.

During an interview on 7/25/11 at 2:00 P.M., administrative staff L revealed that staff should refer to residents by the resident's preferred name and the resident's plan of care should reflect that choice if different than the resident's given name.

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F 241	Continued From page 10 Review of the facility provided undated policy, Resident Rights, documented that the resident has a right to a dignified existence,...and the facility must protect and promote the rights of each resident. The facility failed to ensure staff addressed this resident in a manner of their choice of name, that enhanced the resident's dignity, respect and individuality.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents. Based on observation, interview and record review the facility failed to maintain a clean, safe, and homelike environment for the residents of the facility in 2 of 2 halls and 12 of 24 resident rooms. Findings included: - Maintenance staff Y, on 7/21/11 at 11:20 AM, confirmed the following rooms, common areas, and fixtures in the resident rooms which required repair or replacement: West Hall: 1. Four resident ' s personal bathrooms exhibited a urine odor, and appeared with a dark	F 253		8/25/11

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brown stain on the tile, at the base of the toilets.

2. The ceiling tile above the air conditioner in the hallway, exhibited discoloration and a dark colored, hairy-like substance on the surface.

East Hall:

1. A resident room exhibited cracked window caulking, with holes noted in the trim of the window. Another resident room exhibited broken and cracked molding around the window. Another resident ' s room exhibited cracked caulking around the windows, with holes in the plastic trim around the window.

2. One resident ' s room air conditioner lacked trim around the unit. Another resident room exhibited loose and peeling paint on the edges of the air conditioner unit. Another resident room ' s air conditioner unit exhibited bare wood surrounding the air conditioner unit, creating a non-sanitizable surface.

3. The ceiling tile above the air conditioner in the East Hallway, exhibited a discoloration on the tile with a dark hairy-like substance.

Additional areas of concern:

1. Two of two observed merry walker ' s, noted in use for resident ' s # 17 and 33, exhibited soiled and discolored sheep skin padding to the lower legs of the units. Additionally, the units exhibited old faded material, cut at irregular angles, with frayed edges, hanging from the bottom rails. Interview with maintenance staff Y, indicated at

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F 253	Continued From page 12 that time, the items contained weights to counterbalance the units for safety. 2. During the outside tour, observation revealed 6 white trash bags of aluminum cans, sitting outside the kitchen door. Interview, at that time with Environmental staff P, indicated the staff collected the cans for recycling. The facility failed to maintain a clean and sanitary environment for the residents of the facility.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272		8/25/11

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F 272	Continued From page 13 Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents with 11 selected for sample review. Based on observation, interview, and record review, the facility failed to thoroughly assess 3 resident's (# 37, 4, and 17) for accidents, adl's (activities of daily living), and restraint usage. Findings included: - The faciltiy admitted resident # 37 on 7/13/10, with diagnoses including vascular dementia, obstructive chronic bronchitis, atrial fibrilation, esophageal reflux, myocardia infarction, diabetes mellitus, type II, depression, hypertension, hyperlipidemia, cardiovascular disease and persistent mental disorder. The annual comprehensive MDS (minimum data set) assessment, dated 6/21/11, identified the resident with bims (brief interview of mental status) score of 11 (signifying cognition impaired). The assessment identified one fall without injury since the prior assessment.	F 272		

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The CAAS (Care Area Assessment Summary), dated 6/28/11, identified the resident as a high risk for falls, scoring 16 (with 10 or greater at high risk). The CAAS further indicated, "Medications are assessed and there are no adverse side effects that appear to contribute to a fall. There have been 3 falls since last annual." The CAAS failed to investigate/identifiy all causal factors for contributions to falls for this resident, to ensure the staff developed a comprehensive care plan, to prevent further accidents for this resident.

A Fall Risk Assessment, dated 6/28/11, scored 16 (with 10 or greater indicated at high risk).

The undated, "TOTAL PLAN of PATIENT CARE" plan, identified, "Side rails at night and postiton changes by self, transfer x 2 [with 2 staff assist] with gaitbelt prn (as needed) and used walker and wheelchair."

On 7/25/11 at approximately 5:15 p.m., licensed nursing staff M, lacked comment, although nodded his/her head when questioned what causal factors the staff had identified for this resident's fall risk.

The facility failed to thoroughly assess the causal factors for this resident's fall risks.

- The facility admitted resident # 4 on 5/28/02. Diagnoses included, duodenal ulcer, cva (cerebral vascular accident), hypertension, osteoarthritis, obesity, dysphagia, depression, seizures, and constipation.

The annual, MDS (minimum data set)

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comprehensive resident assessment, dated 8/17/10, identified the resident as not assessable of long and short term memory, severely impaired of decision making skills, and identified the resident required total staff dependence for adl's (activities of daily living).

The CAAS (care area assessment summary), dated 8/31/10 identified the resident as dependent on staff for all adl's except eating. The CAAS lacked identification of causal factors, contributing to this resident's dependency on staff for adl's, to ensure comprehensive care planning.

The resident's "Total Plan of Patient Care," undated, identified the resident required a gerichair for mobility and transferred with a mechanical lift with 2 staff assistance.

On 7/25/11 at approximately 5:15 p.m., licensed nursing staff M, lacked comment, although nodded his/her head when questioned what causal factors the staff had identified for this resident's dependence of adl needs.

The facility failed to thoroughly assess the causal factors for this resident's dependence on staff for activities of daily living care needs.

Findings included:

- The 5/3/2011 MDS (Minimum Data Set) identified the resident with diagnoses which included anemia, atrial fibrillation, hypertension, arthritis, anxiety disorder , Alzheimer's disease,

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and severely impaired cognitive skills. The assessment also documented the resident used a restraint daily, identified as a chair which prevents rising.

The current undated care plan, documented use of the Merry Walker from 10/1/2009 to present, to promote independence. The care plan instructed staff to check with the resident often to ascertain his/her needs, and to reposition between walker and recliner every 2 hours.

The 6/14/11, Pre-restraining assessment documented the resident as alert,disoriented, unsteady on their feet, loses balance, a history of falls, leans backward/forward, does not understand what is being said, cannot comprehend surroundings, affected by environmental noise level, and misinterprets words/sounds. Recommendations documented to continue plan of care with no Plan of Care updates, and the next evaluation 9/11.

Observation on 7/20/11 at 1:35 PM , revealed the resident in the Merry Walker in the hallway, eyes closed, body slumped down in the seat and with head down.
At 1:50 PM, the resident moved the Merry Walker down the East hallway. The resident remained seated, and moved the walker with their feet, and scooted forward on the seat, almost sitting on the strap. Certified nursing staff DJ, repositioned the resident at 2:10 PM, and pushed the Merry Walker to the dining room for cake and ice cream.

On 7/21/11 at 9:25 AM, certified nursing staff D and A, assisted the resident to transfer from the Merry Walker to the toilet. Staff A stated, "The

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resident no longer stands and walks with the Merry Walker alone, usually only when staff walks beside the resident.

On 7/21/11 at 2:50 PM, certified nursing staff Z, stated they worked at the facility for over 2 years. Staff Z, reported they had not witnessed the resident walking in the merry walker alone as they used to do, and explained the resident now just pushed their feet to move the Merry Walker.

On 7/25/11 at 10:30 AM, certified nursing staff T, reported the resident no longer stood and walked with the Merry Walker, just moved their feet over the floor to scoot it, and stated the resident had not stood up and walked with it for several months.

On 7/25/11 at 12:30 PM, licensed staff K, stated the resident no longer stood to walk with the Merry Walker, just used their feet to move it, and added they did not remember when the resident stopped standing to walk with it.

On 7/25/11 at 1:19 PM, licensed nursing staff M, reported they complete the pre-restraining assessment quarterly. "The Merry Walker is the least restrictive device for the resident, and does not need a therapist evaluation to tell them that. A therapist does come in once a week to the facility, but no therapy screens for him/her, to say the Merry Walker is the least restrictive device. The resident no longer stood up and walked in the merry walker, that he/she did walk with staff walking beside the walker, and felt the walker was the best assistive device for the resident. The resident would just have increased falls if placed in a wheelchair. The facility had not tried the resident in a wheelchair since going to the

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F 272	Continued From page 18 merry walker or since the resident had stopped standing and walking in the Merry Walker." The facility, May 2011, Physical Restraint Policy stated: "To continually reassess the resident's functional status to determine that the medical condition requiring restraint continues, that any decline in functional status is related to medical condition, not restraint use, and that negative effects are monitored; no unanticipated negative effects are occurring and benefits continue to outweigh risks." The facility failed to provide an accurate assessment of the resident's current physical functional ability to perform daily activities and the need for the Merry Walker as an assistive device.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		8/25/11

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each assessment.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents with 11 selected for sample review. Based on observation, interview, and record review, the facility failed to review and revise care plans for 2 selected residents (# 28 and 8).

Findings included:

- The facility admitted resident # 28 on 7/3/08.

A, 7/7/08, Initial Activity Assessment (The only activity assessment in the clinical record) identified the resident preferred to attend activities in the afternoon, enjoyed cards, games, crafts/arts, sports, music, reading, writing, television, gardening/plants, talking/conversing, and groups.

The "Total Plan of Patient Care," dated 1/24/11 identified the resident required escort to activities, however, failed to identify activities which the resident might attend.

The residents most recent comprehensive assessment, dated 4/5/11, identified the resident impaired of long and short term memory and severely impaired of decision making skills. The assessment further identified the resident activity preferences included: receiving shower, receiving bed baths, family or significant others involved in care discussions, listening to music, being around animals, such as pets, and

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participating in religious activities or practices.

Review of the April, May and June 2011 activity logs, identified the resident typically participated in television, one to one's, family visits, and an occasional party.

Observation at intermittent activities, (such as a birthday party, bingo, and special outing) during the days of survey, 7/19/11 to 7/21/11 failed to identify the resident attended activities.

On, 7/21/11 at 8:05 a.m. CNA (Certified Nurse Aide) C, reported the resident as totally dependent on staff for cares, and did not enjoy activities, related to hearing difficulties.

Activity staff N, on 7/21/11 at 9:30 a.m., reported the resident participated to the extent possible in some special events, enjoyed one to one's with activity personnel. The staff reported the resident does not enjoy large groups much anymore.

Record review, of the activity logs, for April, May and June, 2011, identified the resident had been provided one on one's approximately 15 times this month, along with some other additional small group activities.

Interview on 7/25/11 at 1:30 p.m. with licensed nursing staff I, reported the resident rarely attends activities, further citing skin integrity issues and the length of time the resident tolerated being up in a chair, as a factor.

On 7/25/11 at approximately 3:00 p.m., interview with activity staff N, reported the residents received only the initial assessment, and with the onset of MDS (Minimum Data Set) 3.0, the staff

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no longer complete other than section O of the MDS for an activity assessment (in addition to the initial assessment.)

The facility failed to review and revise the resident's plan of care for activities, as the resident declined and lacked the ability to participate in activities of choice, independently. The direct care staff lacked knowledge of the resident's activity preferences as a result of this failure to review and revise the plan of care. Therefore, the facility staff failed to assist this resident to activity groups.

- The 2/8/11 MDS (Minimum Data Set) identified resident # 8 with diagnosis which included dementia, hypertension, congestive heart failure, constipation, depression, macular degeneration, chronic obstructive pulmonary disease, and a BIMS (Brief Inventory of Mental Status) score of 4(score of 0-7 indicates severely impaired cognition). The assessment further identified the resident required limited assistance from 1 staff for activities of daily living, and 1 fall with minor injury.

The 2/22/11, CAA(Care Area Assessment)included the resident experienced 2 non-injury falls since last the annual assessment. Both falls in the bedroom attempting to get up and go to the bathroom. Interventions in place.

The current care plan, last reviewed on 5/17/2011, instructed the staff the resident had an unsteady gait, impaired judgement, required staff assistance with toileting, and used a walker to ambulate. It further instructed staff that the resident used a bed alarm, but failed to instructed staff in the times for the alarm.

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The 7/21/11 12:19 PM, licensed nurse M, reported the resident did have a fall Tuesday morning, and determined the alarm was off. Staff talked to the night nurse and this nurse plans to check the alarms more frequently. Staff also stated the facility does not add a new intervention with each fall/incident and said," We only do an intervention if it is pertinent. We do not just add something to write it down."

The 3/15/11 nurses's notes, (no time) documented "The resident found awake sitting on the floor with the resident's back leaning against bed, No sign/symptoms of injury noted, and the resident said "Slipped off bed" initiated day time bed alarm, when in bed neuro checks began, son and physician informed."

The 7/19/11 5:15 AM, nurse's notes documented; " The nurse called to room, and observed resident sitting on the floor at bedside with walker upright beside them. The resident very confused. The fall unwitnessed, neuros started, no noted injuries; Resident put back to bed , bed low, bed alarm on. VS 179/86,sitting 165/76, 98.1, 62,18,O2 93%."

On 7/25/11 /she at 1:20 PM, certified nursing staff D, reported the resident does not use the bed alarm in the daytime, only at night.

On 7/25/11 at 1:59 PM, licensed nursing staff K, reported the bed alarm is only used at night time not during the day time when he lays down.

On 7/25/11 at 2:05 PM, licensed nursing staff M, stated the intervention for the fall on 3/15/11 at 11:10 AM, included the bed alarm on during the

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F 280	Continued From page 23 day when in bed. The facility failed to revise the care plan with the 3/15/11 fall intervention to include the time when staff were to place the bed alarm on the resident.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents, with 11 residents sampled. Based on interview, and record review, the facility failed to provide the necessary care and service related to following a physician order for 1(#24) of the 11 sampled residents. Findings included: - The 11/24/10 physician order, instructed staff to administer Menace 40 milligrams, by mouth daily for an appetite stimulant. The resident's, 2/15/2011 MDS (Minimum Data Set) identified resident #24 with diagnosis which included congestive heart failure, hypertension, fatigue, anxiety disorder, anemia,hypothyroidism, narcolepsy., and cancer without metastasis,with a BIMS (Brief Interview for Mental Status) score of	F 309		8/9/11

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F 309	Continued From page 24 10(8-12 indicates cognition moderately impaired) . On 5/31/11, the pharmacy consultant staff documented ; "From dietary notes 3/3/11, the use of Megace has helped patient with diet intake and enjoyment. The resident's weight is stable and daily diet intake is 75-100%. Consider whether Megace could be discontinued to see if they maintain appetite without the drug." The physician returned the letter signed 6/25/11, and ordered to discontinue the medication. Review of the June 2011 and July 2011, MAR(Medication Administration Record) revealed the facility staff continued to administer the Megace 40 millligrams, daily from 6/26-7/25/2011 to the resident. On 7/25/11 at 2:55 PM, licensed nurse I, verified the letter from the physician ordered the facility staff to discontinue the Megace, and the resident currently received the medication.. On 7/25/11 at 4:47 PM, licensed nurse K, explained the staff overlooked the physician order to discontinue the Megace.. The facility failed to follow the physician's order on 6/25/11 to discontinue the medication for 30 days until identified by the surveyor.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		8/19/11

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prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents. Based on observation and interview, the facility failed to maintain a safe environment for the residents of the facility in 2 of 2 halls and in 15 of the 24 resident rooms. Additionally, the facility failed to ensure safety for resident #8, when the staff failed to implement use of a personal body alarm, as planned.

Findings included:

- During environmental tour of the facility on 7/21/11 at 11:20 AM, with maintenance staff Y, observation revealed the following resident areas in need of repair:

1. Eight of 12 resident rooms on the east hall and 6 of the 12 resident rooms on the west hall contained chair rails, which encircled most of the rooms. These chair rails contained uneven edges, with gouges in the wood, which created splintered edges. Furthermore, the chair rails contained multiple screws which protruded from the wood and not flush with the wood surface. These chair rails created accident hazards for any resident that may touch them. Maintenance staff Y confirmed the hazards and the need for repair.

2. Two of the 12 rooms on the west hall, contained sharp edges on the window trim. Staff

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Y confirmed the need for repair.

The facility failed to maintain a safe and homelike environment for the residents of the facility.

- The 2/8/11 MDS (Minimum Data Set) identified resident # 8 with diagnoses which included dementia, hypertension, congestive heart failure, constipation, depression, macular degeneration, chronic obstructive pulmonary disease, and a BIMS (Brief Inventory of Mental Status) score of 4(score of 0-7 indicates severely impaired cognition). The assessment further identified the resident required limited assistance from 1 staff for activities of daily living, and 1 fall with minor injury.

The 2/22/11, CAA(Care Area Assessment)included the resident experienced 2 non-injury falls since the last annual assessment. Both falls occurred in the bedroom while the resident attempted to get up and go to the bathroom.

The current care plan, last reviewed on 5/17/2011, instructed the staff the resident had an unsteady gait, impaired judgement, required staff assistance with toileting, and used a walker to ambulate. It further instructed staff that the resident used a bed alarm, but failed to instructed staff in the times for the alarm usage.

On 7/21/11 at 8:50 AM, the resident lay on the bed with eyes closed, with an alarm observed hung on the left side of bed, with no lights on it.

On 7/21/11 at 9:00 AM, certified nursing staff V, stated," The resident has a bed alarm, on at all times when in bed, staff know the alarm is on by the blinking green light." He/she picked the alarm

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F 323	Continued From page 27 up to show the surveyor, and stated, "Well it is not on now, the light is not showing" He/she, reported, " The resident is able to ambulate about the facility with a roller walker, said the staff will turn the alarm off when the resident gets up,and they sometimes forget to turn it back on. The resident experienced falls but I can't remember when the last one was." On /21/11 at 9:15 AM, licensed nurse G, stated." The resident is to have the bed alarm at all times when he/she is in bed. The resident uses a roller walker when ambulating, and had a fall this past Tuesday morning, without injury, and new interventions are added to the care plans, by the charge nurse or the Director of Nursing." On 7/25/11,at 1:20 PM, certified nursing staff D, reported the resident does not use the bed alarm in the daytime, only at night. On 7/25/11 at 1:59 PM, licensed nursing staff K, reported the bed alarm is only used at night time not during the day time when he/she lays down 7/25/11 at 2:05 PM, licensed nursing staff M, verified the intervention for the fall on 3/15/11 at 11:10 AM, included the bed alarm on during the day when in bed, as well as during the night. The facility failed to ensure the use of the planned interventions for this resident with falls, to prevent further accidents.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		8/12/11

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F 329	Continued From page 28 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents with 11 residents sampled. Based on interview and record review, the facility failed to ensure 9 of 10 residents reviewed for medications were free unnecessary medications that included parameters for monitoring the pulse for resident #9 that received two cardiac medications and monitoring the blood pressure of resident #27 on duplicative blood pressure medications and monitoring for adverse side effects on Black Box Warnings for residents (# 4, 8, 9, 12, 17, 27, 28, 33, and 37).	F 329		

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Findings included:

- According to the clinical record, the facility admitted resident #9, on 9/19/05.

Review of the Physician's Order Sheet, dated June 2011, recorded diagnoses that included hypertension, atrial-fibrillation, arthritis, congestive heart failure, gastroesophageal reflux disease, erosive esophagitis, constipation, history of myocardial infarction and hemorrhoids.

Review of the Medication Administration Record (MAR), dated July 2011 documented physician orders that included: Toprol XL, 12.5 milligrams, daily for hypertension (dated 4/2/08); digoxin, 0.125 milligrams daily for congestive heart failure (dated 1/15/10), Lasix (furosemide), 60 milligrams daily in the morning for congestive heart failure (dated 7/24/09), Tylenol, 500 milligrams, 1 tablet with Ultram (a pain medication) at 8 A.M. and Noon for arthritis (dated 4/2/08) and Tylenol, 500 milligrams, 2 tablets at bedtime for arthritis pain (dated 4/2/08).

The plan of care, dated 6/7/11 recorded the resident received Lasix daily. Further review of the resident's plan of care lacked evidence of the Black Box Warning for serious adverse side effects of Lasix or Tylenol.

According to the FDA (Food and Drug Administration) MedWatch, dated 1/13/11, recorded "A Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) for acetaminophen.

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According to Lexi-Comp Information Handbook for Nursing, 12th Edition, page 649, recorded a (U.S. Boxed Warning) for Lasix (furosemide), if given in excessive amounts, furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion.

On 7/21/11 at 3:00 P.M., licensed nursing staff M revealed the consulting pharmacist reviewed all medications, adverse reactions and provided the facility an entire list of medications with Black Box Warnings.

Review of the facility listed medications in the resident care plan books, lacked evidence of the Black Box Warning for Tylenol (acetaminophen) and Lasix (furosemide).

The clinical record documented the resident received the Toprol XL, Digoxin, Lasix and Tylenol as ordered.

The clinical record revealed staff documented the resident's pulse prior to administration of the Toprol or digoxin.

The resident's MAR/clinical record lacked evidence of physician parameters for staff monitoring the resident's pulse for the Toprol or digoxin.

During an interview on 7/25/11 at 1:15 P.M., licensed nursing staff M reported that he/she was not aware the resident's Medication Administration Record lacked parameters for the residents pulse prior to administration of the Toprol XL or digoxin. Licensed nursing staff M continued that the information for parameters on

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the resident's pulse was not on the physician's standing orders, and staff use the "standard" for pulse of 60 on digoxin administration

On 7/25/11 at 1:45 P.M., direct care staff H reported the facility parameter for holding the medication digoxin was less than 60 beats per minute.

Review of the facility provided undated documentation information labeled KDHE Physer, directed staff to report a resting pulse less than 55 to the resident's physician.

The facility lacked a policy regarding consistent parameters for the monitoring of resident heart rate with administration of medications for congestive heart failure and antihypertensives.

The facility failed to ensure consistent monitoring parameters for this resident that received two cardiac medications.

The facility failed to ensure this resident's medication was free from unnecessary medication by failure to identify and monitor medications with Black Box Warnings.

- Review of the facility face sheet, recorded the facility admitted resident #27 on 1/16/08.

Review of the Physician's Order Sheet, dated June 2011 and signed by the physician on 6/15/11, recorded diagnoses that included: dementia, hypertension, osteoporosis, coronary artery disease, depression and age-related macular degeneration.

Review of the Care Area Assessment (CAA),

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dated 11/2/10, recorded the resident as independent with decision-making.

Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 7/12/11, recorded the resident with a Brief Interview for Mental Status (BIMS) score of (8) that indicated moderately impaired cognition and required limited assistance from staff for activities of daily living.

Review of the resident's plan of care, dated 7/19/11, documented the resident with syncopal episodes.

Review of the resident's behavior monitoring sheet, dated July 2011, recorded the resident with black out episodes.

Review of the Medication Administration Record (MAR) dated June 2011 documented physician orders that included: Carvedilol, 25 milligrams twice daily for hypertension (dated 10/21/08), Diltiazem ER, 300 milligram capsule daily for hypertension (8/4/09) and Torsemide, 20 milligrams daily for hypertension (dated 10/21/08).
Review of the July 2011 MAR recorded these same medications renewed by the physician on 6/2/11 when the resident returned from the hospital.
The clinical record revealed staff documented the resident received the medications for hypertension as ordered by the physician.

Review of the resident's clinical record revealed a Faxed Communication for to the physician, dated 6/28/11, (untimed) that the resident experienced syncope while ambulating with a staff member and the resident's blood pressure was 86/61.

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Review of the physician' order sheet, dated June 2011, signed by the physician, lacked evidence of physician orders for monitoring the residents blood pressure.

Review of the resident's clinical record revealed "standing" physician orders, signed 5/13/11. These standing orders lacked information regarding the monitoring of the resident's blood pressure with multiple medications for hypertension.

Review of the facility provided undated documentation information labeled KDHE Physer, vital sign parameter sheet recorded systolic less than 90 = to be reported to physician. However, the MAR and plan of care does not address parameters.

The facility lacked a policy to address duplicate hypertensive medications. The policy only addressed duplicate psychotropic medications.

According to the Lexi-Comp Drug Information Handbook for Nursing, 12th Edition, directed the following nursing actions:

"Carvedilol (beta blocker with alpha-blocking activity) pages 237-239, assess potential for interactions with other prescriptions...anything that will effect blood pressure. Monitor laboratory tests, therapeutic effectiveness (e.g.., hypertension, reduction of angina) and adverse response (e.g. congestive heart failure).

Cardizem (antiarrhythmic, calcium channel blocker) pages 422-425, actions include to monitor therapeutic effectiveness according to use (hypertension, angina, atrial fibrillation-flutter or paroxysmal supraventricular tachycardia

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(psvt).

Torsemide (loop diuretic) pages 1427-1428, actions included -monitor laboratory tests, therapeutic effectiveness, and adverse response (e.g. dehydration, electrolyte imbalance e, postural hypotension) on a regular basis during therapy."

During an interview, on 7/25/11 at 12:40 P.M., licensed nursing staff M reported the physician had not given specific parameters regarding the resident's pulse or blood pressure with multiple medications for hypertension or what the goal of therapy was for this resident. Licensed nursing staff M reported the facility uses standing orders and resident blood pressures were monitored monthly.

The facility failed to ensure this resident's medication regimen was free from unnecessary or duplicative medications by failure to adequately monitor this resident's blood pressure for side effects of multiple and duplicate drug therapy.

Review of the resident's medication administration record dated July 2011 revealed physician orders for the medication as follows: Coumadin, 2 milligrams daily, blood thinner for deep vein thrombosis (DVT) (dated 6/9/11), Coumadin, 2.5 milligrams daily (changed on 7/11/11), Tylenol, 500 milligrams, 2 tablets as needed every four hours (6/2/11) and Tylenol, suppository 650 milligrams, one per rectum every 4 hours as needed for pain or elevated temperature.

Review of the clinical record lacked evidence of any Black Boxed Warnings for Coumadin or Tylenol (acetaminophen).

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According to the FDA (Food and Drug Administration) MedWatch, dated 1/13/11, recorded "A Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) for acetaminophen.

According to the Lexi-Comp Drug Information Handbook for Nursing, 12th Edition, page 1497, Warning/Precautions for Coumadin recorded the U.S. Boxed Warning: may cause major or fatal bleeding.

On 7/25/11 at 1:45 P.M., licensed nursing staff I confirmed the resident received the medication Coumadin for a DVT.

On 7/21/11 at 3:00 P.M., licensed nursing staff M revealed the consulting pharmacist reviewed all medications, adverse reactions and provided the facility an entire list of medications with Black Box Warnings.

Review of the facility listed medications in the resident care plan books, lacked evidence of the Black Box Warning for Tylenol (acetaminophen) and Coumadin.

The facility failed to identify and monitor this resident for adverse reactions related to the boxed warning for Tylenol (acetaminophen) and Coumadin.

- Review of resident #12's Medication Administration Record (MAR), dated July 2011, recorded a physician order, dated 4/1/11, to administer Tylenol, 325 milligrams, two tables

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orally, twice daily for "all-over-pain".
Review of the clinical record revealed the resident received the medication as ordered.

Review of the resident's clinical record lacked evidence of the boxed warning for Tylenol on the resident's plan of care.

On 7/21/11 at 3:00 P.M., licensed nursing staff M revealed the consulting pharmacist reviewed all medications, adverse reactions and provided the facility an entire list of medications with Black Box Warnings.

Review of the facility listed medications in the resident care plan books, lacked evidence of the Black Box Warning for Tylenol (acetaminophen).

According to the FDA (Food and Drug Administration) MedWatch, dated 1/13/11, recorded "A Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) for acetaminophen.

The facility failed to identify and monitor this resident for adverse reactions related to the boxed warning for acetaminophen.

- The facility admitted resident # 37 on 7/13/10 with diagnoses including vascular dementia, obstructive chronic bronchitis, atrial fibrillation, esophageal reflux, myocardial infarction, diabetes mellitus, type II, depression, hypertension, hyperlipidemia, cardiovascular disease, and persistent mental disorder.

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Physician orders, dated 7/13/10, instructed staff to administer the following medications:

1. Tylenol, 500mg, a pain/fever reducer, 1-2 tabs by mouth every 4 hours, prn (as needed).
2. Hytrin, an anti-hypertensive, 2mg, by mouth, twice daily and check [the resident's] blood pressure prior to administration.
3. Verapamil, an anti-depressant, 240mg, daily, and check [the resident's] blood pressure prior to administration.
4. Metoprolol, an anti-hypertensive, 50mg, by mouth, daily, and check [the resident's] blood pressure prior to administration.
5. Isosorbide Mononitrate, an anti-hypertensive, 60mg, by mouth, daily.

Additionally, on 9/16/10, the physician ordered:

ES (Extra Strength) Tylenol, a pain/fever reducer, 2 tabs, by mouth, twice daily, for arthritis.

A pharmacy consultant report, dated 9/29/10, identified the recommendation/ consideration to the physician, regarding long term use of Seroquel. At that time, the physician refused/declined any changes to the resident's psychotropic medication usage, and identified the resident as, "Stable." Review of the clinical record, subsequently failed to identify any further recommendations for GDR (gradual dose reduction.)

A comprehensive annual MDS (minimum data set) assessment, dated 6/21/11, identified the resident with a BIMS (brief interview for mental status) score of 11, indicating moderate cognitive impairment.

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The care plan, dated 7/5/11, failed to identify the black box warning for Tylenol.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

Furthermore, the facility obtained orders for this resident with hypertension, to receive multiple medications for treatment of the hypertension, with orders to monitor the resident's blood pressure, prior to administration. However, the facility failed to obtain clarification orders, to set blood pressure parameters for notification of the physician.

Review of the July, 2011, Medication Administration Record, identified the staff monitored the resident's blood pressure, as ordered. However, the facility failed to notify the physician on one occasion, on 7/9/11, when the resident's blood pressure measured 200/112 mmhg (millimeters of mercury).

Interview, with certified nursing staff H, on 7/25/11 at 10:10 a.m., reported the resident's blood pressure is monitored daily before administering the blood pressure medication. If during the monitoring the certified medication nursing staff believed the resident's blood pressure to be out of normal for the resident then the nurse is notified, for physician notification. Documentation in the nursing documentation on that date, lacked such notification to the physician.

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Review of the facility provided, undated, documentation information, labeled, KDHE Physer, directed staff to report a systolic blood pressure greater than 200 and a diastolic blood pressure routinely greater than 90 to the resident's physician.

The facility lacked a policy regarding consistent parameters for the monitoring of the resident's blood pressures with administration of medications for hypertension.

The facility failed to monitor and notify the physician of an elevated blood pressure, and failed to alert the responsible staff to the black box warnings associated with the use of such medications, which required those warnings.

- Review of the clinical records, for resident's who received medications with black box warnings, failed to identify any monitoring of the resident related to adverse reactions and/or the side effects associated with the black box warnings. This affected the following residents:

1. Resident # 4: Physician's orders, dated 2/27/04, ordered Acetaminophen, 500mg, 2 tablets, by mouth, three times daily, for osteoarthritis; Furosemide, 80mg, daily, by mouth, for hypertension, ordered 9/25/06; and Acetaminophen suppository, 650mg, per rectum, as needed, every 4 hours, for pain and/or increased fever, ordered 10/18/06.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions

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(swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."
2. Resident #28: Physician's orders, dated 5/5/10, the physician ordered acetaminophen, 650mg, by mouth or rectum, every 4 hours, as needed; and on 12/9/10 ordered Acetaminophen, 325mg, 1 or 2 tabs, by mouth, every 4 hours, as needed.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

3. Resident #33: Physician's orders, dated 4/8/11, ordered Furosemide, 40mg, twice daily, for congestive heart failure; and Acetaminophen, 500mg, four times daily, for pain on 4/12/11.

The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."
An FDA (Federal Drug Administration),

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MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

4. Resident #17: Physician's orders, dated 3/17/09, ordered Furosemide, 40mg, by mouth, every a.m., for edema; and on 2/22/10 ordered Acetaminophen, 325mg, by mouth three times daily for pain.

The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."
An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

5. Resident #8: Physician's orders, dated 3/16/10, ordered Furosemide, 40mg, daily, by mouth, for congestive heart failure, and Acetaminophen, 325mg, 2 tablets, by mouth, every 4 hours, as needed for pain or elevated temperature; then on 11/23/10 the physician added an as needed order for Acetaminophen, 325mg, by mouth every 4 hours, as needed for pain or elevated temperature.

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F 329	Continued From page 42 An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen." The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion." The facility failed to monitor these residents for adverse reactions and/or side effects for medications with black box warnings.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents with 11 residents sampled. Based on interview and record review, the pharmacist failed to	F 428		8/12/11

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identify and report to the physician and/or director nursing 10 of 10 residents that included residents #(9 and 27) for monitoring pulse and blood pressures with parameters for duplicative cardiac medications; resident #24 a medication continued after the physician ordered it discontinued; and residents # (4,8,9.12, 17, 27, 28, 33 and 37) who lacked monitoring for adverse side effects on Black Box Warning advisements.

Findings included:

- According to the clinical record, the facility admitted resident #9, on 9/19/05.

Review of the Physician's Order Sheet, dated June 2011, recorded diagnoses that included hypertension, atrial-fibrillation, arthritis, congestive heart failure, gastroesophageal reflux disease, erosive esophagitis, constipation, history of myocardial infarction and hemorrhoids.

Review of the Medication Administration Record (MAR), dated July 2011 documented physician orders that included: Toprol XL, 12.5 milligrams, daily for hypertension (dated 4/2/08); digoxin, 0.125 milligrams daily for congestive heart failure (dated 1/15/10), Lasix (furosemide), 60 milligrams daily in the morning for congestive heart failure (dated 7/24/09), Tylenol, 500 milligrams, 1 tablet with Ultram (a pain medication) at 8 A.M. and Noon for arthritis (dated 4/2/08) and Tylenol, 500 milligrams, 2 tablets at bedtime for arthritis pain (dated 4/2/08).

The plan of care, dated 6/7/11 recorded the resident received Lasix daily. Further review of the resident's plan of care lacked evidence of the Black Box Warning for serious adverse side

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effects of Lasix or Tylenol.

According to the FDA (Food and Drug Administration) MedWatch, dated 1/13/11, recorded "A Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) for acetaminophen.

According to Lexi-Comp Information Handbook for Nursing, 12th Edition, page 649, recorded a (U.S. Boxed Warning) for Lasix (furosemide), if given in excessive amounts, furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion.

On 7/21/11 at 3:00 P.M., licensed nursing staff M revealed the consulting pharmacist reviewed all medications, adverse reactions and provided the facility an entire list of medications with Black Box Warnings.

Review of the facility listed medications in the resident care plan books, lacked evidence of the Black Box Warning for Tylenol (acetaminophen) and Lasix (furosemide).

On 7/26/11 at 4:45 P.M., pharmacy consultant AA reported a general discussion with the facility involving Black Box Warnings and that the medications were adequately monitored with the laboratory testing which automatically triggered with the initiation of these medications.

The clinical record documented the resident received the Toprol XL, Digoxin, Lasix and Tylenol as ordered.

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The clinical record revealed staff documented the resident's pulse prior to administration of the Toprol or digoxin.

The resident's MAR/clinical record lacked evidence of physician parameters for staff monitoring the resident's pulse for the Toprol or digoxin.

During an interview on 7/25/11 at 1:15 P.M., licensed nursing staff M reported that he/she was not aware the resident's Medication Administration Record lacked parameters for the residents pulse prior to administration of the Toprol XL or digoxin. Licensed nursing staff M continued that the information for parameters on the resident's pulse was not on the physician's standing orders, and staff use the "standard" for pulse of 60 on digoxin administration

On 7/25/11 at 1:45 P.M., direct care staff H reported the facility parameter for holding the medication digoxin was less than 60 beats per minute.

On 7/26/11 at 4:45 P.M., pharmacy consultant AA acknowledged that staff should monitor the resident's pulse prior to administration of these medication and that the medication administration record should record the physician defined parameters. for the resident's pulse.

Review of the facility provided undated documentation information labeled KDHE Physer, directed staff to report a resting pulse less than 55 to the resident's physician.

The facility lacked a policy regarding consistent

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parameters for the monitoring of resident heart rate with administration of medications for congestive heart failure and antihypertensives.

The facility failed to ensure the consulting pharmacist identified and reported the need for consistent monitoring parameters for this resident that received two cardiac medications.

The facility failed to ensure the consulting pharmacist identified the staff need for Black Box Warnings with adverse consequences associated with the administration of these medications.

- Review of the facility face sheet, recorded the facility admitted resident #27 on 1/16/08.

Review of the Physician's Order Sheet, dated June 2011 and signed by the physician on 6/15/11, recorded diagnoses that included: dementia, hypertension, osteoporosis, coronary artery disease, depression and age-related macular degeneration.

Review of the Care Area Assessment (CAA), dated 11/2/10, recorded the resident as independent with decision-making.

Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 7/12/11, recorded the resident with a Brief Interview for Mental Status (BIMS) score of (8) that indicated moderately impaired cognition and required limited assistance from staff for activities of daily living.

Review of the resident's plan of care, dated 7/19/11, documented the resident with syncopal episodes.

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Review of the resident's behavior monitoring sheet, dated July 2011, recorded the resident with black out episodes.

Review of the Medication Administration Record (MAR) dated June 2011 documented physician orders that included: Carvedilol, 25 milligrams twice daily for hypertension (dated 10/21/08), Diltiazem ER, 300 milligram capsule daily for hypertension (8/4/09) and Torsemide, 20 milligrams daily for hypertension (dated 10/21/08).
Review of the July 2011 MAR recorded these same medications renewed by the physician on 6/2/11 when the resident returned from the hospital.
The clinical record revealed staff documented the resident received the medications for hypertension as ordered by the physician.

Review of the resident's clinical record revealed a Faxed Communication for to the physician, dated 6/28/11, (untimed) that the resident experienced syncope while ambulating with a staff member and the resident's blood pressure was 86/61.

Review of the physician's order sheet, dated June 2011, signed by the physician, lacked evidence of physician orders for monitoring the residents blood pressure.

Review of the resident's clinical record revealed "standing" physician orders, signed 5/13/11. These standing orders lacked information regarding the monitoring of the resident's blood pressure with multiple medications for hypertension.

Review of the facility provided undated

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documentation information labeled KDHE Physer, vital sign parameter sheet recorded systolic less than 90 = to be reported to physician. However, the MAR and plan of care does not address parameters.

The facility lacked a policy to address duplicate hypertensive medications. The policy only addressed duplicate psychotropic medications.

According to the Lexi-Comp Drug Information Handbook for Nursing, 12th Edition, directed the following nursing actions:

"Carvedilol (beta blocker with alpha-blocking activity) pages 237-239, assess potential for interactions with other prescriptions...anything that will effect blood pressure. Monitor laboratory tests, therapeutic effectiveness (e.g.., hypertension, reduction of angina) and adverse response (e.g. congestive heart failure).

Cardizem (antiarrhythmic, calcium channel blocker) pages 422-425, actions include to monitor therapeutic effectiveness according to use (hypertension, angina, atrial fibrillation-flutter or paroxysmal supraventricular tachycardia (psvt).

Torsemide (loop diuretic) pages 1427-1428, actions included -monitor laboratory tests, therapeutic effectiveness, and adverse response (e.g. dehydration, electrolyte imbalance e, postural hypotension) on a regular basis during therapy."

During an interview, on 7/25/11 at 12:40 P.M., licensed nursing staff M reported the physician had not given specific parameters regarding the resident's pulse or blood pressure with multiple medications for hypertension or what the goal of therapy was for this resident. Licensed nursing

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staff M reported the facility uses standing orders and resident blood pressures were monitored monthly.

On 7/26/11 at 4:45 P.M., pharmacy consultant AA acknowledged that the resident needed reevaluation for the need of 3 medications to control blood pressure.

The facility failed to ensure the consulting pharmacist identified and reported the need for consistent monitoring and parameters for this resident that received multiple blood pressure medications..

Review of the resident's medication administration record dated July 2011 revealed physician orders for the medication as follows: Coumadin, 2 milligrams daily, blood thinner for deep vein thrombosis (DVT) (dated 6/9/11), Coumadin, 2.5 milligrams daily (changed on 7/11/11), Tylenol, 500 milligrams, 2 tablets as needed every four hours (6/2/11) and Tylenol, suppository 650 milligrams, one per rectum every 4 hours as needed for pain or elevated temperature.

Review of the clinical record lacked evidence of any Black Boxed Warnings for Coumadin or Tylenol (acetaminophen).

According to the FDA (Food and Drug Administration) MedWatch, dated 1/13/11, recorded "A Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) for acetaminophen.

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F 428	Continued From page 50 According to the Lexi-Comp Drug Information Handbook for Nursing, 12th Edition, page 1497, Warning/Precautions for Coumadin recorded the U.S. Boxed Warning: may cause major or fatal bleeding. On 7/25/11 at 1:45 P.M., licensed nursing staff I confirmed the resident received the medication Coumadin for a DVT. On 7/21/11 at 3:00 P.M., licensed nursing staff M revealed the consulting pharmacist reviewed all medications, adverse reactions and provided the facility an entire list of medications with Black Box Warnings. Review of the facility listed medications in the resident care plan books, lacked evidence of the Black Box Warning for Tylenol (acetaminophen) and Coumadin. On 7/26/11 at 4:45 P.M., pharmacy consultant AA reported a general discussion with the facility involving Black Box Warnings and that the medications were adequately monitored with the laboratory testing which automatically triggered with the initiation of these medications. The facility failed to ensure the consulting pharmacist identified the staff need for Black Box Warnings with adverse consequences associated with the administration of Tylenol (acetaminophen) and Coumadin. - Review of resident #12's Medication Administration Record (MAR), dated July 2011, recorded a physician order, dated 4/1/11, to administer Tylenol, 325 milligrams, two tables	F 428		

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orally, twice daily for "all-over-pain".
Review of the clinical record revealed the resident received the medication as ordered.

Review of the resident's clinical record lacked evidence of the boxed warning for Tylenol on the resident's plan of care.

On 7/21/11 at 3:00 P.M., licensed nursing staff M revealed the consulting pharmacist reviewed all medications, adverse reactions and provided the facility an entire list of medications with Black Box Warnings.

On 7/26/11 at 4:45 P.M., pharmacy consultant AA reported a general discussion with the facility involving Black Box Warnings and that the medications were adequately monitored with the laboratory testing which automatically triggered with the initiation of these medications.

Review of the facility listed medications in the resident care plan books, lacked evidence of the Black Box Warning for Tylenol (acetaminophen).

According to the FDA (Food and Drug Administration) MedWatch, dated 1/13/11, recorded "A Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) for acetaminophen.

The facility failed to ensure the consulting pharmacist identified the staff need for Black Box Warnings with adverse consequences associated with the administration of this medication.

- The facility admitted resident # 37 on 7/13/10

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with diagnoses including vascular dementia, obstructive chronic bronchitis, atrial fibrillation, esophageal reflux, myocardial infarction, diabetes mellitus, type II, depression, hypertension, hyperlipidemia, cardiovascular disease, and persistent mental disorder.

Physician orders, dated 7/13/10, instructed staff to administer the following medications:

1. Tylenol, 500mg, a pain/fever reducer, 1-2 tabs by mouth every 4 hours, prn (as needed).
2. Hytrin, an anti-hypertensive, 2mg, by mouth, twice daily and check [the resident's] blood pressure prior to administration.
3. Verapamil, an anti-depressant, 240mg, daily, and check [the resident's] blood pressure prior to administration.
4. Metoprolol, an anti-hypertensive, 50mg, by mouth, daily, and check [the resident's] blood pressure prior to administration.
5. Isosorbide Mononitrate, an anti-hypertensive, 60mg, by mouth, daily.

Additionally, on 9/16/10, the physician ordered:

ES (Extra Strength) Tylenol, a pain/fever reducer, 2 tabs, by mouth, twice daily, for arthritis.

A pharmacy consultant report, dated 9/29/10, identified the recommendation/ consideration to the physician, regarding long term use of Seroquel. At that time, the physician refused/declined any changes to the resident's psychotropic medication usage, and identified the resident as, "Stable." Review of the clinical record, subsequently failed to identify any further recommendations for GDR (gradual dose reduction.)

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A comprehensive annual MDS (minimum data set) assessment, dated 6/21/11, identified the resident with a BIMS (brief interview for mental status) score of 11, indicating moderate cognitive impairment.

The care plan, dated 7/5/11, failed to identify the black box warning for Tylenol.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

Furthermore, the facility obtained orders for this resident with hypertension, to receive multiple medications for treatment of the hypertension, with orders to monitor the resident's blood pressure, prior to administration. However, the facility failed to obtain clarification orders, to set blood pressure parameters for notification of the physician.

Review of the July, 2011, Medication Administration Record, identified the staff monitored the resident's blood pressure, as ordered. However, the facility failed to notify the physician on one occasion, on 7/9/11, when the resident's blood pressure measured 200/112 mmhg (millimeters of mercury).

Interview, with certified nursing staff H, on 7/25/11 at 10:10 a.m., reported the resident's blood pressure is monitored daily before administering

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the blood pressure medication. If during the monitoring the certified medication nursing staff believed the resident's blood pressure to be out of normal for the resident then the nurse is notified, for physician notification. Documentation in the nursing documentation on that date, lacked such notification to the physician.

Review of the facility provided, undated, documentation information, labeled, KDHE Physer, directed staff to report a systolic blood pressure greater than 200 and a diastolic blood pressure routinely greater than 90 to the resident's physician.

The facility lacked a policy regarding consistent parameters for the monitoring of the resident's blood pressures with administration of medications for hypertension.

Facility consulting pharmacist AA, on 7/26/11 at approximately 4:45 p.m., agreed the reviews conducted monthly, since the resident's admission, should have identified the lack of parameters for blood pressure abnormalities with notification to the physician. Additionally, staff AA reported the facility and the pharmacist consultant discussed, in general, the black box warnings and he/she felt the medications had been adequately monitored with laboratory testing which automatically triggered with the initiation of the medications, as related to Acetaminophen and Furosemide.

- Review of the clinical records, for resident's who received medications with black box warnings, failed to identify any monitoring of the resident related to adverse reactions and/or the

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side effects associated with the black box warnings. This affected the following residents:

1. Resident # 4: Physician's orders, dated 2/27/04, ordered Acetaminophen, 500mg, 2 tablets, by mouth, three times daily, for osteoarthritis; Furosemide, 80mg, daily, by mouth, for hypertension, ordered 9/25/06; and Acetaminophen suppository, 650mg, per rectum, as needed, every 4 hours, for pain and/or increased fever, ordered 10/18/06.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."
2. Resident #28: Physician's orders, dated 5/5/10, the physician ordered acetaminophen, 650mg, by mouth or rectum, every 4 hours, as needed; and on 12/9/10 ordered Acetaminophen, 325mg, 1 or 2 tabs, by mouth, every 4 hours, as needed.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty

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breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

3. Resident #33: Physician's orders, dated 4/8/11, ordered Furosemide, 40mg, twice daily, for congestive heart failure; and Acetaminophen, 500mg, four times daily, for pain on 4/12/11.

The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."
An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

4. Resident #17: Physician's orders, dated 3/17/09, ordered Furosemide, 40mg, by mouth, every a.m., for edema; and on 2/22/10 ordered Acetaminophen, 325mg, by mouth three times daily for pain.

The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."
An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver

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injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

5. Resident #8: Physician's orders, dated 3/16/10, ordered Furosemide, 40mg, daily, by mouth, for congestive heart failure, and Acetaminophen, 325mg, 2 tablets, by mouth, every 4 hours, as needed for pain or elevated temperature; then on 11/23/10 the physician added an as needed order for Acetaminophen, 325mg, by mouth every 4 hours, as needed for pain or elevated temperature.

An FDA (Federal Drug Administration), MedWatch, dated 1/13/11, identified, "A boxed warning highlighting the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) will be added to the label of all prescription drug products that contain acetaminophen."

The Drug Information Handbook for Nursing, 2011, page 649, identified, "A Warning/Precaution [U.S Boxed Warning]: If given in excessive amounts, Furosemide, similar to other loop diuretics, can lead to profound diuresis, resulting in fluid and electrolyte depletion."
The facility failed to monitor these residents for adverse reactions and/or side effects for medications with black box warnings.

On 7/26/11 at 4:45 p.m., pharmacist consultant AA, reported the facility and the pharmacist consultant, discussed, in general, the black box

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warnings and he/she felt the medications had been adequately monitored with laboratory testing which automatically triggered with the initiation of the medications, as related to Acetaminophen and Furosemide.

- The 11/24/10 physician order, instructed staff to administer Menace 40 milligrams, by mouth daily for an appetite stimulant.

The resident's, 2/15/2011 MDS (Minimum Data Set) identified the resident with diagnosis which included congestive heart failure, hypertension, fatigue, anxiety disorder, anemia,hypothyroidism, narcolepsy., and cancer without metastasis,with a BIMS (Brief Interview for Mental Status) score of 10(8-12 indicates cognition moderately impaired) .

On 5/31/11, the pharmacy consultant staff documented ; "From dietary notes 3/3/11, the use of Megace has helped patient with diet intake and enjoyment. The resident's weight is stable and daily diet intake is 75-100%. Consider whether Megace could be discontinued to see if they maintain appetite without the drug."
The physician returned the letter signed 6/25/11, and ordered to discontinue the medication.

Review of the June 2011 and July 2011, MAR(Medication Administration Record) revealed the facility staff continued to administer the Megace 40 milligrams, daily from 6/26-7/25/2011 to the resident.

On 7/25/11 at 2:55 PM, licensed nurse I, verified the letter from the physician ordered the facility staff to discontinue the Megace, and the resident currently received the medication..

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F 428	Continued From page 59 On 7/25/11 at 4:47 PM, licensed nurse K, explained the staff overlooked the physician order to discontinue the Megace. On 7/26/11, at 4:45 PM, pharmacy consultant AA, reported completion of the facility drug regimen review on 6/29/2011, and failed to see that the physician order to discontinue the medication and that the facility staff continued to administer the medication. The facility's pharmacist consultant failed to identify the irregularities of the facility continuation to administer the medication following the physician order to discontinue the Megace.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		8/12/11

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F 441	Continued From page 60 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents. Based on observation, record review, and interview, the facility failed to ensure proper infection control in the laundry to prevent the spread of infections to the residents of the facility. Furthermore, the facility failed to monitor and maintain an infection control program that included staff/resident pets or animals to ensure the prevention of infection or disease in this highly susceptible population. Findings included: - Observation of water temperatures on 7/21/11 at 3:00 p.m., in the facility laundry, with maintenance staff Y, identified the hot water temperature at 147 degrees, Fahrenheit. At that time, the maintenance staff reported, " The recycler went out last week, was reset, it still has not reset like it	F 441		

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should. "

On 7/25/11 at 1:30 p.m., the laundry water temperature, measured at the hand washing sink in the laundry area, tested at 142 degrees, Fahrenheit.

On 7/25/11 at 1:50 p.m., the laundry water temperature, measured at the hand washing sink in the laundry area, tested at 152 degrees, Fahrenheit. Environmental services staff P, reported the water temperature, " Might be lower at this time due to dishwashing on-going [in the kitchen] at this time. " The staff member reported laundry water temperatures are monitored monthly, by the environmental staff. The staff member further indicated, what staff do when the water temperature is below the reported required 160 degree temperature, " I let my administrator know. "

Review of the environmental testing records for the past 5 months, identified the temperature consistently measured 160 degrees, Fahrenheit.

On 7/25/11, at approximately 3:30 p.m., environmental staff P, reported the temperature would be monitored daily for several days, until the temperatures stabilized at 160 degrees, Fahrenheit.
The facility failed to maintain appropriate hot water temperatures for laundry services, to adequately sanitize and to prevent the development and potential spread of infections to the residents of the facility.
- Observation during the survey on 7/19/11, 7/20/11, 7/21/11 and 7/25/11 revealed two small white dogs, roaming in the facility.

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On 7/21/11 at 10:41 A.M., one little white dog entered the private dining 50's room and urinated in front of the exterior door on the carpet runner.

During an interview on 7/21/11 at 1:00 P.M., licensed nursing staff M reported both dogs, were owned by individuals that worked at the facility and came with those employees to work on a daily basis. Licensed nursing staff M continued that the facility kept no files on either animal. Licensed nursing staff M reported the facility staff contacted the hospital regarding animals and as the facility fell within the recommendations provided, did not develop a policy regarding animals or pets.

Review of the the facility provided a faxed form 7/21/11 at 1:18 P.M. from a veterinary clinic revealed one dog was due for a Rabies vaccination on March 4, 2011 and distemper (DHL)/Parvo on 6/25/11.

On 7/21/11 at 1:30 P.M., licensed nursing staff M reported the animal was ill in June and did not receive the required immunizations.

On 7/21/11 at 1:50 P.M., administrative staff O, reported the other dog, was up to date on rabies vaccination, however, lacked the immunization paperwork.

The facility lacked a policy for care of animals or pets.
The facility lacked documentation of immunization and regular health examinations of both dogs observed in the facility.

Review of the Guidelines for Environmental Infection Control in Health-Care Facilities;

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Recommendations of Centers for Disease Control (CDC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC), dated 2003, pages 106-108, recorded:
2. Animal-Assisted Activities, Animal-Assisted Therapy, and Resident Animals
"Animals participating in either Animal-Assisted Activity (AAA) or Animal-Assisted Therapy (AAT) sessions should be in good health and up-to-date with recommended immunizations and prophylactic medications (e.g., heartworm prevention) as determined by a licensed veterinarian based on local needs and recommendations. Regular re-evaluation of the animal's health and behavior status is essential. Animals should be routinely screened for enteric parasites and/or have evidence of a recently completed antihelminthic regime. They should also be free of ectoparasites (e.g., fleas and ticks) and should have no sutures, open wounds, or obvious dermatologic lesions that could be associated with bacterial, fungal, or viral infections or parasitic infestations. Animals should be clean and well-groomed. The visits must be supervised by persons who know the animals and their behavior. Animal handlers should be trained in these activities and receive site-specific orientation to ensure that they work efficiently with the staff in the specific health-care environment. Additionally, animal handlers should be in good health. The most important infection-control measure to prevent potential disease transmission is strict enforcement of hand-hygiene measures (e.g., using either soap and water or an alcohol-based hand rub) for all patients, staff, and residents after handling the animals. Care should also be taken to avoid direct contact with animal urine or feces. Clean-up of these substances from

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F 441	Continued From page 64 environmental surfaces requires gloves and the use of leak-resistant plastic bags to discard absorbent material used in the process. As a general preventive measure, resident animal programs are advised to restrict animals from a) food preparation kitchens, b) laundries, c) central sterile supply and any storage areas for clean supplies, and d) medication preparation areas." The facility failed to implement, monitor and maintain an infection control program regarding the care and supervision of pets and animals to ensure the prevention of infection or disease to all residents, a highly susceptible population, in the facility.	F 441		